MDR Tracking Number: M5-04-0366-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-7-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the electrical stimulation, massage therapy, ultrasound, hot/cold packs, and aquatic therapy were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 4-10-03 to 5-23-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23rd day of February 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended 2/23/04

December 30, 2003

Re: IRO Case # M5-04-0366-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a

claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient injured her lower back in ___ when she was repeatedly lifting flats of plants. She apparently underwent several months of unsuccessful chiropractic treatment, and then changed her doctor to the treating D.C.

Requested Service(s)
Electrical stimulation, massage therapy, ultrasound therapy, hot/cold pack therapy, aquatic therapy 4/10/03-5/23/03

Decision
I agree with the carrier's decision to deny the requested treatment.

Rational
The patient received an adequate trial of conservative treatment prior to the dates in this dispute without relief of symptoms or improved function. She had been treated with medication, therapeutic exercises, passive modalities, lumbar ESIs and manipulations with poor results prior to the treatment in dispute.
It is very doubtful that a patient with disk bulges at L4-5 and L5-S1 with an annular tear at L4-5 would be a candidate for extended chiropractic treatment. Her prognosis would be poor. After a 1/15/03 MRI showed these disk pathologies the patient should have been referred to a neurosurgeon for evaluation and treatment.

The notes provided for this review are repetitious and lack objective, quantifiable findings to support treatment. I question the use of aquatic therapy on a patient with a pain scale of 7/10 and pain radiating into the lower extremities. There is no description of the aquatic exercises in the documentation. Extensive aquatic therapy without documented relief of symptoms or improved function shows that treatment is inappropriate and possibly iatrogenic. Appropriate treatment for this patient during the period in dispute would not include chiropractic care and aquatic exercises.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.